STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105511	A. Building B. Wing	02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hialeah Shores Nursing and Rehab Center	8785 NW 32nd Avenue Miami, FL 33147

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to refer residents, for a Preadmission Screening and Resident Review (PASARR) Level II screening for two (Resident #77, #82) of three residents out of sixteen residents receiving health rehabilitation services for Mental Illness (MI) and/or Intellectual Disability (ID) whom exhibited behaviors. The findings included: 1. Observation of Resident #77 on 2/12/18 at 10:02 am revealed the resident sitting in a wheelchair, receiving therapy and wearing eyeglasses. Record review on 2/13/18 at 11:14 am revealed the following: 1) PARR Level I was completed on 5/26/17 at a local Hospital; 2) Section I, PASARR Level I Screen Decision Making Mental Illness (MI) or suspected MI were checked for Anxiety Disorder, [MEDICAL CONDITION] Disorder and [MEDICAL CONDITION]; 3) Section II, Other Indications for PASARR Screen Decision-Making were checked No; 4) Section IV: PASARR Screen Completion were checked for-No [DIAGNOSES REDACTED]. Level II PASARR not required and 5) Resident admitted to the facility on [DATE]. Review of the Demographic Face Sheet for Resident #77 revealed the resident was originally admitted on [DATE] with diagnoses to include anxiety, [MEDICAL CONDITIONS] and depression. The last admission was on 1/22/18. Review of the Minimum Data Set (MDS) 5-Day Assessment for Resident #77 dated 1/27/18 revealed the Preadmission Screening and Resident Review the resident not currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability and the Brief Interview for Mental Status (BIMS) Summary Score was not scored, indicating cognitive impairment. Review of the Physician order [REDACTED]. Review of the Physician Telephone Order revealed the following: 1) Dated 1/12/18: [MEDICATION NAME] for anxiety, agitation; 2) Transfer resident to { } Psych Unit with [DIAGNOSES REDACTED]. Review of the Behavior Monitoring Sheets for (MONTH) (YEAR) and (MONTH) (YEAR) revealed the resident received the following medications: [REDACTED]. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plans for Resident #77 revealed the following: 1) Problem: Behavioral Problem as evidenced by: Patient began yelling and screaming, physically aggressive, uncooperative, History refuse meds related to (r/t) Diagnosis, Anxiety, [MEDICAL CONDITION] and [MEDICAL CONDITION] disorder (Written 1/22/18, Review 4/22/18) and 2) Problem: Resident is at risk for side effects from antianxiety medication. [DIAGNOSES REDACTED]., new order for [MEDICATION NAME] X (times) 1 dose. The resident had exhibited behavior on several occasions. Review of the Nurses' Notes for Resident #77 dated 1/12/18 at 11:00 am: Resident noted very anxious and confused at this time without apparent cause. Resident wife with resident, trying to slide from wheelchair (w/c), turn aggressive with staff, physically trying to hit the staff. Kicking started early, tried to redirect but resident maintained the same behavior. Staff and wife provided emotional support but ineffective at the time. Called MD to make aware resident's condition and change in behavior. New order given, [MEDICATION NAME] from emergency kit and transfer resident to { } Psych Unit. At 12:00 PM: Ambulance arrived at this time, resident left to { } Psych Unit Hospital with two paramedics and at 10:00 PM: Resident will be admitted to { } Mental Health Unit. Interview with Staff C on 2/15/18 at 11:51 am she stated, He has been out a few times to the hospital for altered mental status. On 1/12/18, the nurse noticed the patient being anxious and confused without apparent reason with the wife present. The patient was attempting to slide down the wheelchair and became aggressive when the staff tried to assist him. If you touch him, he wouldn't let the staff do it. Tried to redirect him and he continued with the same behavior. Called the Medical Doctor (MD), gave order for [MEDICATION NAME] and to transfer to { } Psych. Ambulance came to pick up the resident and was admitted to { } Hospital. He had a [MEDICAL CONDITIONS], communication is limited, strong man and when he gets like that he is very difficult. He has a history of behaviors. Probably should have been reevaluated for a PARR Level II. Interview with Staff D on 2/15/18 at 2:12 PM via Spanish translator stated, Sometimes he will get anxious. When she doesn't understand him, he changes his character. He changes his facial expressions, gets frustrated. Interview with Staff [NAME] on 2/15/18 at 2:42 PM stated, He has behaviors such as episodes of angry, yelling at the staff. Unable to speak but will say a certain phrase[NAME] tana when angry. Will try to hit staff sometimes. Has psychiatric treatment with doctor and takes meds for antipsychotics. Interview with the Social Services Director on 2/15/18 at 4:14 PM stated, PASARR Level I was done on 5/26/17 at a local Hospital with a [DIAGNOSES REDACTED]. No PASARR Level II was done. The patient has a care plan for screaming. I know the resident has had several episodes of altered mental status and the paperwork should have been sent to the Local State agency ( ) for Level II evaluation. 2. Observation of Resident #82 on 2/12/18 at 9:28 am revealed the resident sitting up in bed, talking to herself in Spanish. Record review on 2/13/18 at 9:21 am revealed the following: 1) PASARR Level I was completed on 12/20/17 at a local Hospital; 2) Section I, PASARR Level I Screen Decision Making Mental Illness (MI) or suspected MI was checked for [MEDICAL CONDITION]; 3) Section II, Other Indications for PASARR Screen Decision-Making were checked No; 4) Section IV: PASARR Screen Completion were checked for-No [DIAGNOSES REDACTED]. Level II PASARR not required and 5) Resident admitted to the facility on [DATE]. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Demographic Face Sheet for Resident #82 revealed the resident was originally admitted on [DATE] with diagnoses to include [MEDICAL CONDITION] and [MEDICAL CONDITION]. The last admission was on 12/21/17. Review of the Minimum Data Set (MDS) Admission Assessment for Resident #82 dated 1/02/18 revealed the Preadmission Screening and Resident Review the resident not currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability, Brief Interview for Mental Status (BIMS) Summary Score was not scored, indicating cognitive impairment and Active Diagnoses were Anxiety Disorder, Depression, [MEDICAL CONDITIONS] and Cognitive Decline. Review of the Physician order [REDACTED]. Review of the Behavior Monitoring Sheets for (MONTH) (YEAR) and (MONTH) (YEAR) revealed the resident was receiving the following medications: [REDACTED]. Review of the Care Plan for Resident #82 revealed the following: 1) Problem: Other-Patient screaming at and yelling with nonsensical speech for no apparent reason related to [DIAGNOSES REDACTED]. Review of the Nurses' Notes showed the resident exhibited behavior on the following dates: 12/27/17, 1/30/18, 2/05/18, 2/13/18 and 2/15/18. Interview with Staff C on 2/15/18 at 12:11 PM stated, Have observed her talking to herself. Behaviors noted on 12/27/17, 1/30/18, 2/05/18, 2/13/18, 2/15/18. Probably should have been reevaluated for a ASA Level II. Interview with Staff F on 2/15/18 at 2:38 PM via Spanish translator stated, She has behaviors. Interview with Staff G on 2/15/18 at 2:48 PM stated, Behaviors noted such as screaming and nonsensical talking. Behaviors are noted everyday and intermittently. Review of the PASARR Level I was altered with a different date of 1/23/18 when the Discharging Hospital and Local State agency ( ) completed the Level I Screen on 12/20/17. Interview and record review with the Social Services Director on 2/15/18 at 3:55 PM stated, Responsibilities include when I receive the PASARR from the hospital I review it. I call the hospital and ask about it and review it. PASARR Level I was done on 1/23/18 at a local Hospital with a [DIAGNOSES REDACTED]. She don't have any behaviors. We don't determine the Level II, only the State agency ( ). When the nurse document the behavior, it triggers for a review we keep the MDS and psychiatric consult. I was notified the resident has had several behaviors by nursing. I put in a care plan. No, I did not send the papers to the State agency ( ) for a Level II. Yes, I should have sent the papers to the State agency ( ) for a Level II for review. Denied the PASARR Level I was altered with a different date of 1/23/18 when the Discharging Hospital and Local State agency ( ) completed the Level I Screen on 12/20/17. Interview with the Social Services Assistant on 2/15/18 at 3:57 PM stated, The resident was at a local Hospital and the Level I was done on 1/23/18. Denied the PASARR Level I was altered with a different date of 1/23/18 when the Discharging Hospital and Local State agency ( ) completed the Level I Screen on 12/20/17.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (resident #93) of five residents reviewed for unnecessary medications had an adequate indication for use of an antipsychotic medications out of 24 residents receiving antipsychotic medications. The findings included: Record review of the medical facesheet for resident #93 revealed the resident originally admitted to the facility on [DATE], and readmitted on [DATE]. Observation on 02/12/2018 at 10:22 am revealed resident #93 in her room in bed sleeping; the resident would not respond to her name or any questions. Observation on 02/12/2018 at 2:21 PM revealed resident #93 still sleeping in her bed without any disturbances. Observation on 02/13/2018 at 10:37 am revealed resident #93 in her room in bed sleeping, and could not be easily aroused. Observation on 02/13/2018 at 1:27 PM revealed resident #93 in bed still sleeping; the resident would not wake up when her name was called and continued to sleep. Observation on 02/14/2018 at 11:02 am revealed resident #93 in her room in bed sleeping. Similar to previous observations, the resident would not awake when her name was called; she continued to sleep. Record review of the physician's orders [REDACTED].#93 was prescribed 200 milligrams (mg) of [MEDICATION NAME], an antipsychotic medication, to be given twice daily for [MEDICAL CONDITION] chronic paranoid type (SCPT). Record review of the Medication Administration Record [REDACTED]. Record review of the Psychiatric Consultation dated 01/29/2018 revealed that resident #93 was evaluated by the psychiatrist. It was noted that the resident would continue with the [MEDICATION NAME] medication at the dosage and frequency of 200 mg twice daily. However, the only [DIAGNOSES REDACTED]. and Dementia. It was not indicated that the resident suffered from SCPT, or that the medication was prescribed for it. Record review of the Behavior Monitoring Records for the months of (MONTH) (YEAR) and (MONTH) (YEAR) revealed resident #93 was monitored for delusional behaviors. At the top of the record it was noted, Document each behavior per shift with the number of episodes and initial 'C' for Continuous. Further review of the records revealed no documented behavioral episodes for the resident. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Nurses' Notes for the months of (MONTH) (YEAR) and (MONTH) (YEAR) revealed no documentation of resident #93 displaying any delusional behaviors. Further review of the nurses' notes revealed that on 02/11/2018 the resident was observed in bed with moderate sedation. The resident's vital signs were taken, and it was noted, Patient is on antipsychotic medication [MEDICATION NAME] 200 mg twice a day. MD notified and new orders given to decrease [MEDICATION NAME] to 100 mg twice daily. Patient will be under closely monitoring. Call light at reach. Record review of the Telephone physician's orders [REDACTED].#93. Interview with the Certified Nursing Assistant (Staff B) on 02/14/2018 at 1:10 PM, via translation by the Licensed Practical Nurse (Staff A), revealed that resident #93 was totally dependent on staff for activities of daily living (ADL) care. Sometimes when she worked with the resident she could be resistive, but she would have to be patient with the resident and try again with her. She said that sometimes the resident would sleep a lot, and sometimes she would not. Resident #93 was calm and less active yesterday and today, but not sleepy. Interview with Staff A on 02/14/2018 at 1:34 PM revealed that sometimes resident #93 could be very resistive and non-cooperative with care. The resident received [MEDICATION NAME], 100 mg, twice a day via peg tube for SCPT; it used to be 200 mg twice a day but was discontinued because she was observed to be sedated on 02/11/2018. Resident #93 was not receiving [MEDICATION NAME] medication prior to her discharge; she came back from the hospital already prescribed the medication. Record review of the resident #93's closed medical record prior to her hospitalization on [DATE] revealed that she was not receiving the [MEDICATION NAME] medication. Further review of the nurses' notes for the months of (MONTH) (YEAR) and (MONTH) (YEAR) revealed no documented episodes of delusional behaviors. Record review of the hospital records for resident #93 only revealed an order for [REDACTED]. Observation and interview on 02/14/2018 at 1:57 PM revealed resident #93 in bed still sleeping. Staff A and the Director of Nursing (DON) were present in the room, and tried to arouse the resident. The resident moved to her side, but did not open her eyes; she started to scratch her sacral area. Resident #93 did not respond to her name when the staff members called her. Staff A and the DON said that she was sleepy, but responsive; they stated the resident was not sedated. Interview with the Psychiatrist on 02/14/2018 at 2:29 PM, via telephone, revealed that she had been following resident #93 prior to her coming to the facility, and when she was hospitalized . At the previous facility she prescribed the resident [MEDICATION NAME] for [MEDICAL CONDITION] and reacting to internal stimuli. The resident was receiving a higher dosage of the medication, but on 02/11/2018 the medication was reduced when the resident was observed to be sedated. The psychiatrist said that she could not completely take the resident off of the medication, but attempt gradual dose reductions. The resident needed to be monitored, and if she continued with sedation, then they would have to re-evaluate the resident. When informed of the observations of resident #93 continuously sleeping throughout the day, she said that she was going to speak to the facility and give orders for neurological checks, more close monitoring of the resident, and holding any medications that may cause the resident sedation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON and the Assistant Director of Nursing (ADON) on 02/14/2018 at 2:53 PM revealed that the ADON spoke to psychiatrist on the phone and she instructed to start resident #93 on neurological checks every six hours for 48 hours, lab work immediately, [MEDICATION NAME] reduced to 50 mg daily, and hold if too sedated. When asked if nursing staff should have informed the psychiatrist of the resident's sleepiness, both staff members said that Staff A was going to call the psychiatrist before ending of her shift. Record review of the facility's policy and procedures titled, Behavior Assessment and Monitoring, dated 1/1/05, Revised 1/1/18, revealed policy did not specifically address antipsychotic medications. It was revealed, If the resident is being treated for [REDACTED]. The staff will continue to document (either in progress notes, behavior assessment forms, or other comparable approaches) specific information about problem behaviors or moods If psychoactive medications are used to treat behavioral symptoms, the nursing staff and Attending Physician will periodically reconsider their indication and consider whether they can be tapered or document why tapering cannot or should not be attempted.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure coordination of care for one (Resident #11) of one resident out of nine residents receiving hospice services as evidenced by failure to ensure adequate evidence of communication between the facility and the hospice provider. Written documentation was not available in the medical records. Services provided by Hospice were not coordinated and communicated in written documentation. The findings included: Record review of the Hospice Contract revealed a local Hospice Care Company entered into a written agreement with this facility effective on (MONTH) 28, (YEAR). Coordination of Care: Hospice and Facility shall communicate with one another regularly. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day. Review of the Demographic Face Sheet for Resident #11 revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) Quarterly Assessment for Resident #11 dated 5/23/17 revealed the resident was cognitively impaired, total dependence with one person physical assist for ADLs (Activities of Daily Living) and was coded for Hospice Care. Review of the physician's orders [REDACTED].#11 received Hospice care from a local Hospice Care Company. Review of the Hospice care plan (written 11/03/17) revealed the resident was on Hospice care with a [DIAGNOSES REDACTED]. Interview with the Hospice Certified Nursing Assistant (CNA) on 2/14/18 at 10:28 am it was stated, When I come in I do bed bath, make her bed, do her hair, little housekeeping, put some on lotion, some cream, everything. Come in the morning everyday, five days a week. I don't write down what I do, I memorize it and when I get home, I put it in my computer. No note left for the facility. Nobody ask me to leave a note here on what I do. Interview with the Hospice Nurse on 2/14/18 at 12:12 PM it was stated, I come to see her one time a week or PRN (as needed) if there is a problem. When I come, I evaluate her from head to toe. When I come, I document in my company computer every visit and bring the notes to the facility every two weeks. Interview with Staff H on 2/15/18 at 9:26 am stated, The hospice comes to see the patient and they put their notes in the resident's chart in the section for hospice in the back of the chart. They are to put their notes in the section every time they come to see the resident. Don't know if the CNA has a binder to sign in but Hospice Nurse would put her notes in the section. I agree that the nurses' notes should be in the chart. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON) on 2/15/18 at 9:38 am it was stated, CNA has a separate binder and she signs in when she comes in. I don't know if they do thinning. They probably overlooked the notes being in the chart. The notes for (MONTH) (YEAR) and (MONTH) (YEAR) were faxed to the facility on yesterday to put into the chart. Subsequent interview at 10:13 AM, she stated, The reason why the (MONTH) notes were in the chart was because the resident was on crisis care. She is no longer on crisis care. Interview with the Hospice Nurse on 2/15/18 at 2:16 PM stated, She started on continuous care on 11/02/17 and finished 11/07/17. I put the notes in the chart and I removed them. They told me to remove them because it was too much paper in the chart. The notes are in my system. I brought notes from 11/02/17-11/07/17 and 11/08/17-02/02/18. I remove the notes every month for the next month. Reviewed hospice notes on 2/15/18 from 11/02/17-11/07/17 and 11/08/17-02/02/18, which were brought in by the Hospice Nurse.